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NEW REPORT: INSURERS ON AVERAGE SPENT LESS THAN 1 PERCENT OF PREMIUM DOLLARS ON HEALTH CARE QUALITY IMPROVEMENT ACTIVITIES IN 2011

First-Ever Data on Quality Spending Shows Insurers Spent Combined $2.3 Billion on Quality Improvement

New York, NY, March 22, 2013—Health insurance companies reported spending an average of less than 1 percent of the premiums they collected from policyholders in 2011 on activities directly supporting improvement of health care quality, according to a new Commonwealth Fund study. The report, which looks at differences in medical loss ratios, consumer rebates, and quality improvement expenses based on insurance companies' corporate structure and ownership, finds that insurers spent a combined $2.3 billion on direct quality improvement activities—an average of $29 per subscriber. The Affordable Care Act's medical loss ratio rule requires insurers to spend at least 80 or 85 percent of premiums on medical claims and quality improvement activities, or else pay rebates to consumers. For purposes of calculating medical loss ratios, quality improvement expenses are those for activities that are likely to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and increase wellness and health promotion.

The report, *Insurers' Medical Loss Ratios and Quality Improvement Spending in 2011*, by Mark Hall of Wake Forest University and Michael McCue of Virginia Commonwealth University, examines median expenditures on quality improvement among plans that were provider-sponsored (owned, operated, or jointly managed by a health care system or by a group of physicians or other health care providers), non-provider-sponsored, nonprofit, for-profit, publicly traded, and non–publicly traded. Using the median expenditure gives equal weight to each insurer's quality improvement spending per member, regardless of the company's size.

According to the report, there was substantial variation in reported quality improvement expenditures among insurers. Carriers in the top quartile of the range reported spending more than $40 per member, compared to less than $12 per member in the bottom quartile. The median investment in quality improvement among provider-sponsored plans was $37 per member, compared to $23 spent by non-provider-sponsored plans. Nonprofit plans spent $35 per member,

compared to $19 spent by the median for-profit plan, which spent the least. Publicly traded and non-publicly traded plans spent similar amounts per member ($26 and $22, respectively).

A breakdown of insurers' quality improvement expenditures finds that 17 percent of the total spending on these defined activities went to health information technology, 51 percent to improving health outcomes, 9 percent to preventing hospital readmissions, 10 percent to patient safety, and 13 percent to wellness.

Separately, on the medical loss ratio reporting forms, insurers also report the dollar amount they pay to providers to encourage quality improvement through incentives and bonuses. This total amounted to an additional 0.35 percent of premium revenues in 2011. This study analyzes direct quality improvement expenses reported by insurers in 2011 which are linked to identifiable quality improvement activities.

"These data can provide insurers with helpful insights into how the industry is approaching quality improvement," said Commonwealth Fund vice president Sara Collins. "The hope is that insurers will take the information and use it to determine if they are making an appropriate investment in improving quality and, ultimately, their members' health and well-being."

Additional Findings

Nonprofit and provider-sponsored plans were more likely than for-profit and non-provider-sponsored plans to meet the health reform law's medical loss ratio requirement that they spend at least 80 to 85 percent of premiums on medical claims and quality improvement. In the individual market, only 8 percent of nonprofit plans owed consumer rebates, compared to 47 percent of for-profit insurers. Seven percent of provider-sponsored plans in the individual market owed rebates compared to 40 percent of non-provider sponsored plans.

- In the small and large group markets, 3 to 8 percent of nonprofit plans owed rebates compared to about a quarter of for-profit plans.
- While publicly traded insurers were more likely to owe rebates, the median rebates they owed on individual market policies were smaller than those owed by non–publicly traded insurers ($94 vs. $174).

Moving Forward

The report highlights the nature of competitive forces in the health insurance marketplace. In the absence of information on quality of care that can be easily understood, many consumers will likely continue to select health insurance plans based on costs and benefits alone, providing less of an incentive for insurers to invest in quality improvement, the authors say. The Affordable Care Act requires health plans to report more detailed information on quality improvement efforts. Although these steps could provide further incentives for insurers to invest in quality, more robust measures may be needed. The report recommends that to stimulate competitive pressures for health plans to improve quality of care, HHS should synthesize and disseminate these new quality improvement data in a way that consumers find useful and relevant.

"The requirement to spend a minimum of premium dollars on medical care and quality improvement rather than on administrative costs or profits provides an incentive for insurance companies to support efficient, high-quality health care," said Commonwealth Fund president David Blumenthal, M.D. "However, in order for our health care system to guarantee that all Americans receive the best possible health care, we need all major health care stakeholders—insurers, providers and others—to make substantial commitments to far-reaching, dramatic quality improvements."

Data and Methods

Data for this study come from the medical loss ratio (MLR) rebate forms that insurers filed with the Centers for Medicare and Medicaid Services for 2011. Insurers report separately in each state in which they have enrollment, for a total of 2,441 state insurers that offered comprehensive health insurance. However, insurers with enrollment of less than 1,000 have less actuarial "credibility," meaning that they face greater year to year variation in medical utilization and costs; therefore, under federal regulations, these smaller insurers are presumed to meet the MLR rebate regulation, and they are excluded from the analysis. There were a total of 947 insurers with 1,000 or more members per state in at least one market segment (individual, small group or large group). Of these, 855 reported quality improvement data. Because the excluded plans are small, they represent only 1 percent of the membership of all reporting insurers for 2011.

Using NAIC data and the AIS Directory of Health Plans, each insurer is categorized according to three corporate traits, noting that an insurer might well have more than one of these traits. Insurers were categorized by the status of their parent company rather than the status for each subsidiary. The median test was used to test differences in median rebate per member as well as medical loss ratio across plans with and without each of these corporate traits. Some results were sensitive to whether quality improvement expenses were measured as averages versus based on the median among each insurer's per-member spending. For instance, for-profit insurers in aggregate reported more spending per member than did nonprofits. That measure, however, gives more weight to large insurers' quality improvement spending whereas analysis of median expenditures gives equal weight to each insurer's quality expense per member.

The Commonwealth Fund is a private foundation supporting independent research on health policy reform and a high performance health system.